MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07400

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; LENGTH OF STAY (in this place): 48 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 427 Walnut St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; STREET ADDRESS (If rural, give location): 427 Walnut St.

3. NAME OF DECEASED (Type or Print): Annie (First) Patricia (Middle) Amann (Last)

4. DATE OF DEATH: August 16, 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: May 11, 1888

9. AGE last birthday: 71 yrs.; If under 1 year: Months.; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Kady

14. MOTHER'S MAIDEN NAME: Sarah Gavin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no; (If year, give war or dates of service): XX

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Paul Amann

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Diabetic gangrene Rt leg — Interval Between Onset and Death: 3 weeks

260 Antecedent cause(s)

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetes mellitus — 20 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1946, to Aug 16, 1949, that I last saw the deceased alive on Aug 16, 1949 and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE: James Wetherston Jr (Degree or title): MD ADDRESS: Piedmont, W.Va. DATE SIGNED: Aug 17, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: Aug. 19, 1949; NAME OF CEMETERY OR CREMATORY: St. Peter's; LOCATION (City, town, or county) (State): Westernport, Md.

DATE REC'D BY LOCAL REG.: Aug 6/49; REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: Ellsworth S, Boal; ADDRESS: 111 Church St. Westernport, Md

RECEIVED
AUG 19 1949
BUREAU V. S.

Within corporate limits

Murray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

07401

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage
STREET ADDRESS (If rural, give location) Newtown

3. NAME OF DECEASED (Type or Print) (First) Arthur (Middle) Augustas (Last) Athey

4. DATE OF DEATH (Month) Aug (Day) 17 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Jan 25, 1877

9. AGE last birthday 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY Coal Mines

11. BIRTHPLACE (State or foreign country) Flintstone Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles Athey

14. MOTHER'S MAIDEN NAME Mollie Hendrickson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Mrs Arthur A. Athey.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Primal Pneumonia	2 days
Antecedent cause(s)	(b) Facial erysipelas	8 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

052

11

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Injection Rage — 8 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 3, 1949, to Aug 17, 1949, that I last saw the deceased alive on Aug 16, 1949 and that death occurred at 8 a m., from the causes and on the date stated above.

SIGNATURE A. Alan G. Nerenny (Degree or title) M.D. ADDRESS Cumberland Md DATE SIGNED Aug 20 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Aug 19, 1949

NAME OF CEMETERY OR CREMATORY Mt Savage Meth. Cemetery

LOCATION (City, town, or county) Mt Savage (State) Md

DATE REC'D BY LOCAL REG. Aug. 19, 1949

REGISTRAR'S SIGNATURE Walter R. Lantz M.D.

24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 23 1949
BUREAU V. S.

Within corporate limits

M

C

T

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07402

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 320 Central Ave.

3. NAME OF DECEASED (Type or Print) (First) Robert (Middle) W. Winfred (Last) Barnes, Jr.

4. DATE OF DEATH (Month) August (Day) 10 (Year) 1949

5. SEX Male
6. COLOR OR RACE COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH June 17, 1949
9. AGE last birthday yrs. If under 1 year Months 1 Days 23 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert W. Barnes
14. MOTHER'S MAIDEN NAME Jean Ashby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Robert W. Barnes

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

774 Immediate cause (a) furunculosis

159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) prematurity, birth weight

(c) 2 lbs. 2 oz.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 1, 1949, to Aug. 10, 1949, that I last saw the deceased alive on Aug. 10, 1949, and that death occurred at 3:15 P m. from the causes and on the date stated above.

SIGNATURE Elizabeth Bring (Degree or title) M.D. ADDRESS La Vale DATE SIGNED Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug. 12 49
NAME OF CEMETERY OR CREMATORY Rose Hill Cem.
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Aug. 12, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein ADDRESS Cumberland Md.

RECEIVED
AUG 16 1949
BUREAU V. S.

07403

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jackson Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) Jackson Street

3. NAME OF DECEASED (Type or Print) (First) Noah (Middle) — (Last) Beaman

4. DATE OF DEATH (Month) Aug. (Day) 30, (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Sept 3 1866 Aug 30 49
9. AGE last birthday 83 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner - Retired
10b. KIND OF BUSINESS OR INDUSTRY Coal Mine
11. BIRTHPLACE (State or foreign country) Lonaconing
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Beaman -
14. MOTHER'S MAIDEN NAME Lorena Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. ✓
17. INFORMANT Noah Beaman Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a)	Acute myocarditis	4 wks
605 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Cystostomy (Bladder opened)	2 yrs -
93a	(c)	Cystitis -	3 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION 1947
19b. MAJOR FINDINGS OF OPERATION Enlarged Prostate
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from July, 1947, to August 30, 1949, that I last saw the deceased alive on Aug. 30, 1949, and that death occurred at 5:30 A m., from the causes and on the date stated above.

SIGNATURE P E Berry (Degree or title) M. D. ADDRESS Piedmont DATE SIGNED W. Va 8/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 2, 1949
NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery
LOCATION (City, town, or county) Moscow (State) Md.

DATE REC'D BY LOCAL REG. 8/31/49
REGISTRAR'S SIGNATURE Jannette M Pool
24. FUNERAL DIRECTOR M. Eichhorn, ADDRESS Lonaconing Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 3 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07404

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland; LENGTH OF STAY (in this place) 25 yrs; STATE MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS La Vale, R.F.D. #1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland; STREET ADDRESS (If rural, give location) La Vale, R.F.D. #1

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Siegmond Frederick (Last) Beck

4. DATE OF DEATH: (Month) Aug (Day) 2 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 17 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: wholesale grocery

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John D Beck

14. MOTHER'S MAIDEN NAME: Francis Fradiska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 714-05-5804

17. INFORMANT: Ellen Brown Beck (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage - Hemiplegia (rt) — Interval Between Onset and Death: 10 days.

331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility

83a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: —

(CITY OR TOWN) (COUNTY) (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from ....., 19....., to Aug 1, 1949, that I last saw the deceased alive on Aug 1, 1949, and that death occurred at 3.45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Hazel R. Eichart M.D. ADDRESS 36 Greene St Cumberland Md DATE SIGNED Aug 3-49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Aug 4 49

NAME OF CEMETERY OR CREMATORY: Greenmount Cem

LOCATION (City, town, or county): Cumberland

(State): Md

DATE REC'D BY LOCAL REG.: August 4, 1949

REGISTRAR'S SIGNATURE: Miles R. Frantz M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc.

ADDRESS: Cumberland

RECEIVED
AUG 9 1949
BUREAU V. S.

NAME: CERTIFICATE OF BIRTH ON FILE IN NOTE → MED. EXAMINERS CASE:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 10-19-49 LL 07405

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) 1½ days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Edward EDGAR	Bear	8	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	Nov. 22 - 1920	28 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Laborer	Farming	Mt. Savage, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John H. Bear	Anna Mary Carbine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
yes WW II	215-16-4401	John H. Bear

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Subarachnoid hemorrhage — 24 hrs.

8195 **Antecedent cause(s)**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

170a (b) Contusion of brain

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture and lacerations of left arm

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
Accident	Highway	Mt. Savage	Allegany	Md.

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☑	HOW DID INJURY OCCUR?
8	19	1949	4:20 p.m.		Auto ran into Box-Car on Siding

22. I hereby certify that I attended the deceased from Aug. 20, 1949., to Aug. 20, 1949., that I last saw the deceased ~~alive~~ dead on Aug 20, 1949., and that death occurred at 5:15 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Benedict Skotarelic	M.D.	R² Cumberland Md	8/20/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8-23-1949	St. Patrick's Cemetery	Mt. Savage,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-22-49	Mrs. Laney A. Roe	Jacob Hafer	Frostburg, Md.

RECEIVED
AUG 24 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07406

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH· COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) HENRY	(Middle) WALTER	(Last) BOOTH	4. DATE OF DEATH	(Month) Aug. (Day) 29, (Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 12-10-1886	9. AGE last birthday: 62 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired coal miner	10b. KIND OF BUSINESS OR INDUSTRY: coal mines	11. BIRTHPLACE (State or foreign country): Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Nelson Booth	14. MOTHER'S MAIDEN NAME: Dorothy Ann Lynch				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY No.: 214-01-6693	17. INFORMANT AND ADDRESS: Mrs. Henry Booth, Eckhart, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) cancer of right lung — 2 years

163 Antecedent cause(s)

47d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1949, to 8-29, 1949, that I last saw the deceased alive on 8-28, 1949, and that death occurred at 9:20 P.m., from the causes and on the date stated above.

SIGNATURE: Adolf Wolfering (Degree or title) M.D. EST ADDRESS: Frostburg Md. DATE SIGNED: 8-31-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 9-2-49	NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery	LOCATION (City, town, or county) (State): Eckhart, Md.
DATE REC'D BY LOCAL REG.: 8-31-49	REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 3 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07407

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 2yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) I2 W. Second St.

3. NAME OF DECEASED (Type or Print): (First) Patricia Rae (Middle) (Last) Boyer

4. DATE OF DEATH: (Month) Aug. (Day) I9, (Year) I949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: May I7, I947

9. AGE last birthday: 2yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David R. Boyer

14. MOTHER'S MAIDEN NAME: Gilda C. Arbogast

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT: Mrs. Gilda Boyer [redacted]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

199.1 **Immediate cause** (a) Acute cardiac failure

55e **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Rhabdomyosarcoma of back with Metastasis to lungs

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☑, *Inspection* ☐, *Inquiry* ☑ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) Benedict Skotarelic M D ADDRESS R2 Cumberland Md DATE SIGNED 8/19/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF Aug. 20, I949; NAME OF CEMETERY OR CREMATORY St. Patrick Cem; LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. Aug. 20, 1949; REGISTRAR'S SIGNATURE Walter R. Frantz M.D.

24. FUNERAL DIRECTOR James F. Scaepelli ADDRESS Cumberland, Md.

V8. A15A

RECEIVED
AUG 23 1949
BUREAU V. S.

Within corporate limits

07408

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 43 Hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Pa — COUNTY: Franklin
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Middleburg
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Gerald (Middle) (Last) Brechbiel

4. DATE OF DEATH: (Month) Aug. (Day) 10 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: April 23-1925

9. AGE last birthday: 24 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of wnrk done during most of working life, even if retired): Collector & Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Keller Brechbiel

14. MOTHER'S MAIDEN NAME: Bessie Brant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. #2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert K. Brechbiel

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage & contusion of brain — Interval between onset and death: about 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) due to a fracture of the skull
(c) Automobile accident

819.5
170c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Rt. #51, Hwhy. — (CITY OR TOWN): 2 miles east of Cumberland, — (COUNTY): Alleg. — (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): 8/9/49 10:30P m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Driver blinded by lights Car went off road, hit telephone pole

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. — ADDRESS: H.V. Deming M.D. Cumberland Md. — DATE SIGNED: Aug. 10-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Aug. 13, 1949 — NAME OF CEMETERY OR CREMATORY: Cedar Hill — LOCATION (City, town, or county) (State): Greencastle, Penna.

DATE REC'D BY LOCAL REG.: Aug. 11, 1949 — REGISTRAR'S SIGNATURE: Walter K. Dantz M.D. — 24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
AUG 16 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

07409

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND LENGTH OF STAY (in this place) 30 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Co. Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 576 Louisiana Ave

3. NAME OF DECEASED (Type or Print): (First) Nellie (Middle) (Last) Broadrup

4. DATE OF DEATH: (Month) Aug (Day) 27 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 30 1894

9. AGE last birthday: 55 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Corbs Mill Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Deal

14. MOTHER'S MAIDEN NAME: Myrtle Fiethmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yr (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Chester H. Ayers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Lung Infection	4 days
345 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 87d	(b) Atelectasis	4 days
	(c) Multiple Sclerosis	20 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1946, to Aug. 27, 1949, that I last saw the deceased alive on Aug 26, 1949, and that death occurred at 9:35 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. Aug. 27, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Aug 30 49 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem | LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REG. Aug. 29, 1949 | REGISTRAR'S SIGNATURE Walter R. Lantz, M.D. | 24. FUNERAL DIRECTOR ADDRESS Louis Stein Inc Cumberland Md

RECEIVED
SEP 5 1949
BUREAU V. S.

Within corporate limits: DR. WEISMAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07410

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 307 FRANKLIN STREET

3. NAME OF DECEASED (Type or Print): (First) GERALD (Middle) (Last) BRODE

4. DATE OF DEATH: (Month) AUGUST (Day) 14, (Year) 19 49

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 8/9/91

9. AGE last birthday: 58 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TINSMITH

10b. KIND OF BUSINESS OR INDUSTRY: B. & O.R.R.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U S a

13. FATHER'S NAME: JOHN BRODE

14. MOTHER'S MAIDEN NAME: ELLEN FITZGERALD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): yes

16. SOCIAL SECURITY NO.: 219-03-9049

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute left ventricular failure	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial Infarction, fresh (and old)	4 days (?)
420.1 94a	(c) Thrombosis Coronary artery Coronary Sclerosis due to arteriosclerosis	4 days ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, General — ?

19a. DATE OF OPERATION: No

19b. MAJOR FINDINGS OF OPERATION: No

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): No — (CITY OR TOWN): No — (COUNTY): No — (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): No m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? No

22. I hereby certify that I attended the deceased from Aug 10, 1949, to Aug 14, 1949, that I last saw the deceased alive on Aug 13, 1949, and that death occurred at 1 10 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Harold A. Weisman	MD	122 Bedford St Cumberland, Md	8/14/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8-17-49	St Peter & Paul's Cem	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 15, 1949	Walter R. Dantz, M.D.	Louis Stein Sons	Cumberland

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AUG 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07411

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 192 W. Main St.,

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 192 W. Main St.,

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) EDMUND (Last) DAVIES

4. DATE OF DEATH: (Month) Aug. (Day) 11 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 8-9-1875

9. AGE last birthday: 74 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired stonemason

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Davies

14. MOTHER'S MAIDEN NAME: Mercey Appleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If year, give war or dates of service: Yes. 1904-1907

16. SOCIAL SECURITY NO.: 220-10-2285

17. INFORMANT AND ADDRESS: John E. Davies, Jr., Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Thyroid — Interval Between Onset and Death: 2 years

194 **Antecedent cause(s)**

55c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: May 1948

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Thyroid

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, 19..., to Aug 11, 1949, that I last saw the deceased alive on Aug 8, 1949, and that death occurred at 3:00 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm Lane MD — ADDRESS: Frostburg Md — DATE SIGNED: Aug 12 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 8-13-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 8-13-49 — REGISTRAR'S SIGNATURE: Dan. Stanley N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md. — ADDRESS

RECEIVED
AUG 15 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07412

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 36 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 430 Arch Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 430 Arch Street

3. NAME OF DECEASED (Type or Print): (First) Nannie (Middle) P. (Last) Davis

4. DATE OF DEATH: (Month) August (Day) 3 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 2 1895

9. AGE last birthday: 54 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House Wife

11. BIRTHPLACE (State or foreign country): Keyser, Mineral Co, W. Va.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Lewis Brewer

14. MOTHER'S MAIDEN NAME: Jennie Iser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ernest F. Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Dilatation of Heart — Duration

450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetes Mellitus

61 (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1949, to 8-3-, 1949, that I last saw the deceased alive on 8-3-, 1949, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE W. F. Williams (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 8-4-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: August 6 1949 | NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery | LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Aug. 6, 1949 | REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight | ADDRESS: Cumberland, Md.

RECEIVED
AUG 9 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07413

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland. | LENGTH OF STAY (In this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.
STREET ADDRESS (If rural, give location) Furnace St.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Charles	B.	DeHaven		8	21	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	June 4 1870	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter.
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Luray Va.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Andrew DeHaven.
14. MOTHER'S MAIDEN NAME: — Harmons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT: F.P.Allender

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	2 Mo
4222 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Chronic Myocarditis	3 Yrs.
	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Aug 15, 1949, to Aug 22, 1949, that I last saw the deceased alive on Aug 16, 1949, and that death occurred at 12:35 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M. D.		110 S. Centre St.	Aug. 22, 1949

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug 24 49	Rose Hill Cem	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 23, 1949	Winter L. Hantz, M.D.	Louis Stein Sons,	Cumberland

VS. A15

7

RECEIVED
AUG 24 1949
BUREAU V. S.

Wilson

07414

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place) 12 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 167 Church Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 167 Church Street

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ELLEN (Last) DEMPSEY

4. DATE OF DEATH: (Month) August (Day) 24 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Sept 3, 1859

9. AGE last birthday: 89 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Broderick

14. MOTHER'S MAIDEN NAME: Mary Mullan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Joseph Dempsey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardiac Insufficiency	One Week
422.2 Antecedent cause(s)	Myocarditis And Myocardial Degeneration	
186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Not Specified as Rheumatic	One Year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture left shoulder and left elbow 7-10-49 — 45 Days

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: Home

(CITY OR TOWN): Westernport (COUNTY): Allegany (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): July 10 1949 8 A m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Fell Down Stairs

22. I hereby certify that I attended the deceased from July 10, 1949, to Aug 24, 1949, that I last saw the deceased alive on Aug 24, 1949, and that death occurred at 7:15 P m., from the causes and on the date stated above.

SIGNATURE: Paul R Wilson (Degree or title) M.D. ADDRESS: Piedmont, W. Va. DATE SIGNED: Aug 26, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: August 27, 1949 NAME OF CEMETERY OR CREMATORY: St. Gabriels Cem. LOCATION (City, town, or county) (State): Barton, Maryland

DATE REC'D BY LOCAL REG.: Aug. 27/49 REGISTRAR'S SIGNATURE: R Baynhaker M.D

24. FUNERAL DIRECTOR: Ellsworth S. Boal ADDRESS: 111 Church St. Westernport, Md.

RECEIVED
AUG 29 1949
BUREAU V. M.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07415

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Dr Van Demer

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, Md.; LENGTH OF STAY (in this place) 1 Day; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rt. 3, Valley Road, Cumberland, Rural; STREET ADDRESS (If rural, give location) Rt. 3, Valley Road

3. NAME OF DECEASED (Type or Print): (First) Minnie (Middle) (Last) Deremer

4. DATE OF DEATH: (Month) August (Day) 16 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 10-24-1870

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Penna. Garrettsville

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel O'Neal

14. MOTHER'S MAIDEN NAME: Elizabeth Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT: Mrs. John Greise

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage with Rt. Hemiplegia	48 hours
331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes mellitus	?
61	(c) Hypertension	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 Aug, 1949, to 16 Aug, 1949, that I last saw the deceased alive on 16 Aug 1949, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Alfred Van Demer — ADDRESS Cumberland, Md. — DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify) Burial | DATE THEREOF 8-19-49 | NAME OF CEMETERY OR CREMATORY P.O.S. of A. | LOCATION (City, town, or county) (State) Centreville Pa.

DATE REC'D BY LOCAL REG. Aug. 17, 1949 | REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. | 24. FUNERAL DIRECTOR Alton Barefoot — Bedford, Pa. | ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

H.W. Van Ommen

RECEIVED
AUG 23 1949
BUREAU V. S.

Within corporate limits

Dr. Dick Williams

07416

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 517 Louisiana Ave.	STREET ADDRESS (If rural, give location) 517 Louisiana Ave.

3. NAME OF DECEASED (Type or Print) (First) Cecelia (Middle) Mary (Last) Dotson				4. DATE OF DEATH (Month) August (Day) 25 (Year) 1949	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 12, 1881	9. AGE last birthday 68 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) W. Va.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Gillispie			14. MOTHER'S MAIDEN NAME Mary Alice Lambert		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Fred R. Dotson		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	30 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	Unknown
	(c)	

331

83a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan 1947, 19....., to 8/25/49, 19....., that I last saw the deceased alive on 8/25/49, 19....., and that death occurred at 12 13 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. Williams	MD	Cumberland	8/26/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 27, 1949	Hill Crest Cemetery	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 27, 1949	Wrater R. Frantz, MD	Charles L. George	Cumberland, Md.

RECEIVED
AUG 30 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07417

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A17

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Locust Grove R.F.D. #6

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland
STREET ADDRESS (If rural, give location): Locust Grove, R.F.D. #6

3. NAME OF DECEASED (Type or Print): (First) Selina (Middle) E. (Last) Dixon

4. DATE OF DEATH: (Month) August (Day) 31 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Dec 30 1860

9. AGE last birthday: 88 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Hampshire Co W. Va.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Thos Alderton

14. MOTHER'S MAIDEN NAME: Barbara Allender

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Phoebe O Baker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage (apoplexy) — Interval Between Onset and Death: 3 days

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 28, 1949 to Aug 31, 1949 that I last saw the deceased alive on Aug 28, 1949 and that death occurred at 8 30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Sept. 1 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Sept 3 '49 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cem | LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Sept. 2, 1949 | REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. | **24. FUNERAL DIRECTOR** ADDRESS: Louis Stein Inc Cumberland Md

RECEIVED
SEP 5 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07418

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 71 +
HOSPITAL OR INSTITUTION OR STREET ADDRESS 112 Maple St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 112 Maple St.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Catherine (Last) Goodyear

4. DATE OF DEATH (Month) Aug (Day) 21 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Sept 6 1877
9. AGE last birthday 71 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY Hotel
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John M. Goodyear
14. MOTHER'S MAIDEN NAME Harriet Huff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-5875
17. INFORMANT Mrs Elizabeth Deter (Sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis & Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH 10 yrs

170 Antecedent cause(s)

50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma breast — 6 months

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) Cumberland (COUNTY) Alleg. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ —
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from May 10, 1949, to Aug 21, 1949, that I last saw the deceased alive on 8/21/49, 19....., and that death occurred at 2 35 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
[signature] M.D. Cumberland Md 8/22/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Aug 24 49
NAME OF CEMETERY OR CREMATORY St Peter & Paul Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Aug. 23, 1949
REGISTRAR'S SIGNATURE Winter R. Hantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc. ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 30 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07419

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

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VS-A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland. — LENGTH OF STAY (in this place) 69 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 719 Emily St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 719 Emily St.

3. NAME OF DECEASED (Type or Print): (First) Theresa (Middle) B. (Last) Hall

4. DATE OF DEATH: (Month) Aug (Day) 13 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct 30, 1879

9. AGE last birthday: 69 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Laurence Baumhauer

14. MOTHER'S MAIDEN NAME: Caroline Trestle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Clara Baumhauer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio Vascular

442 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Renal Disease — Unknown

131a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28, 1949, to 8-13, 1949, that I last saw the deceased alive on 8-9, 1949, and that death occurred at 6.30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. F. Williams M.D. — ADDRESS Cumberland — DATE SIGNED 8-15-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Aug 16 49 — NAME OF CEMETERY OR CREMATORY: St Peter & Pauls Cem — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Aug. 15, 1949 — REGISTRAR'S SIGNATURE: Winter L. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

RECEIVED
AUG 23 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH 07420

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE W. Va. COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgely
STREET ADDRESS (If rural, give location) Carpenters Addt. ✓

3. NAME OF DECEASED (Type or Print) (First) Baby Boy (Middle) (Last) Hansford

4. DATE OF DEATH (Month) (Day) (Year) Aug. 31, 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Infant

8. DATE OF BIRTH 8-30-49

9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours 7 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Hansford

14. MOTHER'S MAIDEN NAME LallaSciese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT George Hansford

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intracranial Hemorrhage — 7 hours

760.5 160a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) premature baby — 6½ months

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30-, 1949, to 8-31-, 1949, that I last saw the deceased alive on 8-30-, 1949, and that death occurred at ....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M D ADDRESS 59 Green St. DATE SIGNED 8-31-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 9-1-49

NAME OF CEMETERY OR CREMATORY Zion Memorial

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Sept. 1, 1949

REGISTRAR'S SIGNATURE Walter R. Bantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

VS. A15

RECEIVED
SEP 5 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07421

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 1 Mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 190 Wineow St.

3. NAME OF DECEASED (Type or Print): (First) Calvin (Middle) (Last) Holliday

4. DATE OF DEATH: (Month) Aug. (Day) 15, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 3-4-1889

9. AGE last birthday: 60 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Used Car lot

11. BIRTHPLACE (State or foreign country): Somerset Co, Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Jesse Holliday

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT: Margaret Baker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary Embolism	30 days
592 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 1314	(b) Chronic Nephritis	Unknown
II	(c) Pneumonitis	30 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 16 19 49 to Aug 15 19 49, that I last saw the deceased alive on Aug 14 19 49, and that death occurred at 10:34 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

D. L. Rees M.D. 104 Decatur St Cumberland 8/16/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 8-17-49

NAME OF CEMETERY OR CREMATORY: Springs Cem.

LOCATION (City, town, or county) (State): Springs, Penna.

DATE REC'D BY LOCAL REG.: Aug. 16, 1949

REGISTRAR'S SIGNATURE: Winter R. Brantz, M.D.

24. FUNERAL DIRECTOR: Stanley Thomas

ADDRESS: Salisbury, Penna.

VS. A15

RECEIVED
AUG 23 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07422

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 801 Manns Terrace

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) Clinton (Last) Holtzhour

4. DATE OF DEATH (Month) Aug. (Day) 10, (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 7/27/1881

9. AGE last birthday 68 yrs.
If under 1 year: Months | Days
If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Rural Box servicing corp.

11. BIRTHPLACE (State or foreign country) Meyersdale, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George Holtzhour

14. MOTHER'S MAIDEN NAME Ella I. Clymer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-05-4297

17. INFORMANT Mrs. Ella S. Holtzhour

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Intracerebral Hemorhage	24h.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Atherosclerosis	24h.
331 / 330	(c) Essential Hypertension - mild	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION No

19b. MAJOR FINDINGS OF OPERATION No

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No

(CITY OR TOWN) (COUNTY) No (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) No m.

INJURY OCCURRED While at Work ☐ Not While At work ☐ No

HOW DID INJURY OCCUR? No

22. I hereby certify that I attended the deceased from 12/4, 1948, to Aug 10, 1949, that I last saw the deceased alive on Aug 10, 1949, and that death occurred at 1:30 P.m., from the causes and on the date stated above.

SIGNATURE Danielle C. Weissmanuers (Degree or title) ADDRESS 122 Bedford St Cumberland Md DATE SIGNED 8/14/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 8/13/49

NAME OF CEMETERY OR CREMATORY Hillcrest

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Aug. 13, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

RECEIVED
AUG 16 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07423

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 13 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 411 Averitt Ave

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 411 Averitt Ave

3. NAME OF DECEASED (Type or Print): (First) Sarepta (Middle) Ellen (Last) Hovermale

4. DATE OF DEATH: (Month) August (Day) 7 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 22 1902

9. AGE last birthday: 47 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House

10b. KIND OF BUSINESS OR INDUSTRY: House Wife

11. BIRTHPLACE (State or foreign country): Elk Garden, West Virginia.

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Albert Garner

14. MOTHER'S MAIDEN NAME: Blanche Barrack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: William J. Hovermale

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma Breast

170 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

50 (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/4, 1949, to 8/7, 1949, that I last saw the deceased alive on 8/7, 1949, and that death occurred at 5-25 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

George M Vernon M.D. 128 Union St. August 8, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: August 9 1949 | NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery | LOCATION (City, town, or county): Cumberland | (State): Maryland

DATE REC'D BY LOCAL REG.: Aug. 9, 1949 | REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight | ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
AUG 16 1949
BUREAU V. S.

Within corporate limits
Rozum

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07424

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 627 Elwood St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 627 Elwood St.

3. NAME OF DECEASED (Type or Print): (First) Leona (Middle) Frances (Last) Jackson

4. DATE OF DEATH: (Month) Aug (Day) 10 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb 24, 1904

9. AGE last birthday: 45 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harry F. Housworth

14. MOTHER'S MAIDEN NAME: Mary E. Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO. (If year, give war or dates of service): 214-16-2500

17. INFORMANT AND ADDRESS: James A. Jackson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Coronary occlusion — Interval between onset and death: Acute

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b):

T3d (c): Chronic myocarditis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/1, 1948, to 8/10, 1949 that I last saw the deceased alive on 8/7, 1949 and that death occurred at 4 m., from the causes and on the date stated above.

SIGNATURE: John N. Rozum (Degree or title) M D — ADDRESS: Cumberland Md — DATE SIGNED: 8/12/49.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 12, 1949	Davis Memorial Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 12, 1949	Winter K. Kantz, M.D.	John J. Hafer	Cumberland Md

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AUG 16 1949
BUREAU V. S.

Dr. Wolverton Sr.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07425

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Franklin-rural — LENGTH OF STAY (in this place) 27 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Franklin-rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 mi. North of Westernport	STREET ADDRESS (If rural, give location) 1 mi. North of Westernport

3. NAME OF DECEASED (Type or Print) (First) Ida (Middle) May (Last) Kenner			4. DATE OF DEATH (Month) August (Day) 18 (Year) 1949		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Sept. 28, 1870	9. AGE last birthday 78 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Work	10b. KIND OF BUSINESS OR INDUSTRY Own-Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Jonas J. Folk		14. MOTHER'S MAIDEN NAME Susannah Shultz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO. xxxx	17. INFORMANT Zelda Ritchie			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Rheumatic Pericarditis	2 yrs
416 Antecedent cause(s)		
90a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) E Silesky Pepet Md	40 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic Phlebitis	10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 5, 1949, to Aug 18, 1949, that I last saw the deceased alive on Aug 18, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James H. Wolverton Sr.	M.D.	President W.Va.	8/20/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE August 21, 1949	NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.	LOCATION (City, town, or county) Moscow	(State) Maryland
DATE REC'D BY LOCAL REG. Aug 21/49	REGISTRAR'S SIGNATURE [illegible]	24. FUNERAL DIRECTOR Ellsworth S. Boal	ADDRESS 111 Church St. Westernport, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
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BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07426

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 6 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) Rt. 4 Frejico Farms

3. NAME OF DECEASED (Type or Print): (First) Osea (Middle) Peter (Last) Kidwell

4. DATE OF DEATH: (Month) Aug (Day) 23 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 17 1885

9. AGE last birthday: 64 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Owner. Driver.

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): E. River Mills, W Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Kidwell

14. MOTHER'S MAIDEN NAME: Sarah Largent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 370-30-3721

17. INFORMANT AND ADDRESS: Martha Parsons

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 hrs

Antecedent cause(s) (b) Arteriosclerosis — Interval Between Onset and Death: Unknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertensive C.V. Disease — Interval Between Onset and Death: Unknown

443 93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/21/49, to 8/22/49, that I last saw the deceased alive on 8/23/49, and that death occurred at 4:40 P.M., from the causes and on the date stated above.

SIGNATURE A. T. Vocs (Degree or title) MD ADDRESS 40 Decatur St DATE SIGNED 8/25/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Aug. 26, 1949

NAME OF CEMETERY OR CREMATORY: Davis Memorial

LOCATION (City, town, or county) (State): Near Cumberland, Md

DATE REC'D BY LOCAL REG.: Aug. 26, 1949

REGISTRAR'S SIGNATURE: W. R. Lantz, M.D.

24. FUNERAL DIRECTOR: Lowe Stein Sons

ADDRESS: Cumberland Md.

RECEIVED
AUG 30 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07427

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Allegany — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing — LENGTH OF STAY (In this place): MARYLAND — HOSPITAL OR INSTITUTION OR STREET ADDRESS: St. Mary's Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing — STREET ADDRESS (If rural, give location): St. Mary's Terrace

3. NAME OF DECEASED (Type or Print): (First) Marion (Middle) Brown (Last) Lashbaugh

4. DATE OF DEATH (Month) (Day) (Year): Aug 25 1949

5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed — 8. DATE OF BIRTH: Jan 29 1874 — 9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework — 10b. KIND OF BUSINESS OR INDUSTRY: Own Home — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Brown — 14. MOTHER'S MAIDEN NAME: Mary Stratton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT: Mrs. Edna Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

631 **Immediate cause** (a) Pulmonary Embolism — 3 days

135b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Operation for the repair of Cystocele — 2 wks

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Aug 10 1949 — 19b. MAJOR FINDINGS OF OPERATION: Relaxed - Prominent — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 22, 1949, to Aug 25, 1949, that I last saw the deceased alive on Aug 24, 1949, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE: J. Norman Reaves, M.D. (Degree or title) — ADDRESS: Westernport Md — DATE SIGNED: 8/25/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Aug. 27 '49 — NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery — LOCATION (City, town, or county) (State): Moscow, Md.

DATE REC'D BY LOCAL REG.: 8/25/49 — REGISTRAR'S SIGNATURE: Jannette M Bond — 24. FUNERAL DIRECTOR: M. Eichhorn — ADDRESS: Lonaconing Md

VS-A15

RECEIVED
SEP 3 1949
BUREAU V. S.

Evidence for addition in 18c shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07428

FILM No. G 122 SEP 27 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (in this place) 74 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 111 Howard Street,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport,
STREET ADDRESS (If rural, give location) 111 Howard Street,

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) E (Last) Laughlin.

4. DATE OF DEATH (Month) August (Day) 28, (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 10, 1875.
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant
10b. KIND OF BUSINESS OR INDUSTRY Owner.
11. BIRTHPLACE (State or foreign country) Westernport, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John W. Laughlin.
14. MOTHER'S MAIDEN NAME Ellen Byrnes.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Charles J. Laughlin.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Senility with mention of Senile Dementia — One Year

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Chronic Myocarditis and myocardial degeneration not specified as Rheumatic (9-27/49 -ams)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition and Anorexia — 3 Months

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 10, 1946 to Aug. 28 1949, that I last saw the deceased alive on Aug. 26, 1949, and that death occurred at 12:45 P. m., from the causes and on the date stated above.

SIGNATURE Paul A Wilson (Degree or title) M.D. ADDRESS Piedmont, W. Va. DATE SIGNED Aug 29, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept. 1, 1949.
NAME OF CEMETERY OR CREMATORY St. Peters Cemetery.
LOCATION (City, town, or county) (State) Westernport, Md.

DATE REC'D BY LOCAL REG. Aug 30/49
REGISTRAR'S SIGNATURE [illegible] M.D.
24. FUNERAL DIRECTOR W. Harold Fredlock, Jr. ADDRESS Piedmont, W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

I

T

RECEIVED
SEP 1 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

07429

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 53 Centennial St.

3. NAME OF DECEASED (Type or Print): (First) FRED (Middle) (Last) LAYMAN

4. DATE OF DEATH: (Month) Aug. (Day) 6 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 5-2-1886

9. AGE last birthday: 63 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Layman

14. MOTHER'S MAIDEN NAME: Elizabeth Knepp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mrs. Hazel Wade, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	peritonitis	3 days
Antecedent cause(s) (b)	ruptured gastric ulcer	3 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

540.1
1170

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8-4-49

19b. MAJOR FINDINGS OF OPERATION: peritonitis, ruptured gastric ulcer

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-3-, 1949, to 8-6-, 1949, that I last saw the deceased alive on 8-6, 1949, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE: L Phillips (Degree or title) MD ADDRESS: 59 Green St. DATE SIGNED: 8-8-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 8-9-1949
NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: Aug. 8, 1949
REGISTRAR'S SIGNATURE: O.R. Lantz, M.D.

24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

VS. A16

RECEIVED
AUG 16 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07430

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland R.D. — LENGTH OF STAY (In this place) 70 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Greenspring R.F.D. #1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 612 Sylvan Ave.

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) Christopher (Last) Leydig
4. DATE OF DEATH: (Month) Aug. (Day) 31 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug. 8 1884
9. AGE last birthday: 65 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk, Western Maryland R.R.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Christopher Leydig
14. MOTHER'S MAIDEN NAME: Louise Bower
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowo): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-16-4961
17. INFORMANT: Mrs. J.C. Boekhouse

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	Unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	10 yrs -
	(c)	

443
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/31, 1949, to 8/31, 1949, that I last saw the deceased alive on 8/30, 1949, and that death occurred at 2:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) R.B. Markey M.D. — ADDRESS 49 Greene St Cumberland, Md — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Sept 3 1949	Hillcrest	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept. 2, 1949	Miles K. Lantz M.D.	Harvey A. Zeigler	Hyndman, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 5 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07431

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH COUNTY Allegany — MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS 372 Penna. Ave	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland — COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland STREET ADDRESS (If rural, give location) 372 Pennsylvania Ave

3. NAME OF DECEASED (Type or Print)	(First) Elmer	(Middle) U.	(Last) Linaburg	4. DATE OF DEATH (Month) Aug	(Day) 26	(Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours / Min.
Male	White	Married	Aug 4 1889	60 yrs.			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector	10b. KIND OF BUSINESS OR INDUSTRY B & O Ry	11. BIRTHPLACE (State or foreign country) Allegany Co. Md	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Geo E. Linaburg		14. MOTHER'S MAIDEN NAME Cristine Twigg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes, give war or dates of service) World War	16. SOCIAL SECURITY NO. 705-07-2257	17. INFORMANT, AND ADDRESS Julius E Linaburg

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	Twelve
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fat advanced Coronary Sclerosis ?	
	(c)	

420.1
440

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8-25, 1949, to 8-26-, 1949, that I last saw the deceased alive on 8-25-, 1949, and that death occurred at 1 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams M.D.	Cumberland	8-27-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 28 '49	Evergreen Mem Cem	Cumberland Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 27, 1949	Walter R. Frantz, M.D.	Louis Stein Inc	Cumberland

RECEIVED
AUG 30 1949
BUREAU V. S.

Within corporate limits DR.W.F.WMS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07432

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE WEST VIRGINIA COUNTY MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FORT ASHBY
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ADA (Middle) E. (Last) LONG

4. DATE OF DEATH: (Month) AUGUST (Day) 4, (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: AUG. 14, 1871

9. AGE last birthday: 77 yrs. If under 1 year: Months ; Days ; If under 24 hrs.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HENRY DERMER

14. MOTHER'S MAIDEN NAME: SADIE E. BLAIR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocardial Degeneration

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Chronic Cholecystitis
(c) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: (a) ? (b) 4224 / 93d (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-30-, 1949, to 8-4-, 1949, that I last saw the deceased alive on 8-4-, 1949, and that death occurred at 3:20 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm. F. Williams Cumberland 8-4-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Aug. 6 1949

NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery

LOCATION (City, town, or county) (State): Fort Ashby W.Va.

DATE REC'D BY LOCAL REG.: Aug. 6, 1949

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George

ADDRESS: Cumberland Md.

VS-A15

RECEIVED
AUG 9 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07433

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 37yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 27 Boone St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 27 Boone St.

3. NAME OF DECEASED (Type or Print): (First) Adam (Middle) (Last) Lowery

4. DATE OF DEATH: (Month) Aug. (Day) 23 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 23, 1882

9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Emp River Plat.

10b. KIND OF BUSINESS OR INDUSTRY: Potomic Edison

11. BIRTHPLACE (State or foreign country): Indiana Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin L. Lowery

14. MOTHER'S MAIDEN NAME: Anna Growden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Wife Mrs Minnie Lowery

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163 Immediate cause (a) Carcinoma of Lung — Interval between onset and death: 6 mon.

Antecedent cause(s)

47d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocarditis — 6 mon.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 24, 1949, to Aug. 24, 1949, that I last saw the deceased alive on Aug. 24, 1949, and that death occurred at 5:25 P. m., from the causes and on the date stated above.

SIGNATURE: Clyde K. Jones (Degree or title) M. D. — ADDRESS: Cumberland — DATE SIGNED: 8/26/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 8/26/49 — NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug. 25, 1949 — REGISTRAR'S SIGNATURE: Winter K. Wantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland

RECEIVED
AUG 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

017434

Reg. Dist. No. 14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie; LENGTH OF STAY (In this place) Life
   HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellerslie
   STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) ~~Lowery~~ (Middle) HARRY IRVIN (Last) LOWERY

4. DATE OF DEATH: (Month) August (Day) 18 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 5 1877

9. AGE last birthday: 71 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): C.E. Engineer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Palo Alto Pennsylvania

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Lewis R. Lowery

14. MOTHER'S MAIDEN NAME: Emma L. Lowery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Mrs. Harry Lowery

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163 Immediate cause (a) Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: 2½ yrs.

47d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 1947

19b. MAJOR FINDINGS OF OPERATION: Carcinoma Rt. Lung

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ~~Cancer~~

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1947, to Aug, 1949, that I last saw the deceased alive on 18 Aug, 1949, and that death occurred at 6:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John A Topper MD ADDRESS Hyndman Pa DATE SIGNED 8/24/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): DATE THEREOF August 21, 1949; NAME OF CEMETERY OR CREMATORY: Palo Alto Cemetery; LOCATION (City, town, or county) Hyndman, Pa. R.D.1 (State)

DATE REC'D BY LOCAL REG. August 20 1949; REGISTRAR'S SIGNATURE: J. Lloyd Wolfe

24. FUNERAL DIRECTOR: Harvey A. Leigler, Hyndman Pa ADDRESS

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AUG 24 1949
BUREAU T. S.

07435

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Detmold Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) Detmold Street

3. NAME OF DECEASED (Type or Print) (First) Clarence (Middle) Valentine (Last) McKenzie

4. DATE OF DEATH (Month) Aug (Day) 12 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH October 20 1883
9. AGE last birthday 65 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mining
10b. KIND OF BUSINESS OR INDUSTRY Digging Coal
11. BIRTHPLACE (State or foreign country) Avilton Md. U.S.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elijah McKenzie
14. MOTHER'S MAIDEN NAME Rebecca Garlitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-05-2916
17. INFORMANT Clarence McKenzie, Jr

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of left Jaw (Bone) — INTERVAL BETWEEN ONSET AND DEATH 9 mo

196 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

45d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 6 mo ago
19b. MAJOR FINDINGS OF OPERATION Same
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5, 1949, to 8/12, 1949, that I last saw the deceased alive on 8/12, 1949, and that death occurred at 6 00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul Eugene Frye M.D. ADDRESS Lonaconing Md DATE SIGNED 8/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug. 15
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg, Allegany (State) Md

DATE REC'D BY LOCAL REG. 8/15/49
REGISTRAR'S SIGNATURE Jannette M Bool
24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 29 1949
BUREAU T. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07436

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
LENGTH OF STAY (in this place) 71 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vocke Rd Rt 5

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) Vocke Rd. Rt 5 Box 361

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) (Last) Metzner

4. DATE OF DEATH (Month) Aug (Day) 2 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Aug 19 1877
9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Peter Martz
14. MOTHER'S MAIDEN NAME Margaret Martz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Andrew L Metzner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) congestive heart failure	years
252.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) thyrotoxic heart disease	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from in 1946 and July 2, 1949, to Aug 1, 1949, that I last saw the deceased alive on Aug 1, 1949, and that death occurred at 2 A.M. Vocke Rd. m., from the causes and on the date stated above.

SIGNATURE Colin Brings (Degree or title) M.D. ADDRESS La Vale DATE SIGNED Med.

23. BURIAL, CREMATION, REMOVAL (Specify) Cremated
DATE THEREOF Aug 4 '49
NAME OF CEMETERY OR CREMATORY St Ambrose Cem
LOCATION (City, town, or county) Cresaptown (State) Md

DATE REC'D BY LOCAL REG. Aug. 3, 1949
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07437

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near McCoole; LENGTH OF STAY (in this place) 3 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural - McCoole, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - McCoole, Md.; STREET ADDRESS (If rural, give location) near McCoole, Md.

3. NAME OF DECEASED (Type or Print): (First) Harold (Middle) Alston (Last) Michael, Jr.

4. DATE OF DEATH: (Month) Aug. (Day) 21, (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 8/18/49

9. AGE last birthday: yrs. If under 1 year: Months; Days 3; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Keyser, W.Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Alston Michael

14. MOTHER'S MAIDEN NAME: Anna Lee Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Henry Alston Michael, Sr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) INTERCRANIAL HEMORRHAGE	3 days.
760.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 160a	(b) Difficult. Prolonged. Labor.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 18, 1949, to Aug 21, 1949, that I last saw the deceased alive on Aug 20, 1949, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
E. G. Courrier	M.D.	Keyser W. Va.	8/22/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/22/49	Dayton Cemetery	Near McCoole, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 22/49			Keyser, W.Va.

VS. A15

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AUG 29 1949
BUREAU V. S.

Within corporate limits

07438

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 319 Greene St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 319 Greene St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Catharine R. Millman

4. DATE OF DEATH (Month) (Day) (Year) Aug. 6, 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Feb 5, 1879
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Francis X. Millman
14. MOTHER'S MAIDEN NAME Sarah Ann Cole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. None
17. INFORMANT Miss. Lydia Millman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Exhaustion Acute & Anaemia — INTERVAL BETWEEN ONSET AND DEATH 2 mos

581.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertrophic Cirrhosis of liver with ascites — 8 months

124.6 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Started with Jaundice

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to Aug 6, 1949, that I last saw the deceased alive on Aug 6, 1949, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) F. Alan G. Murray M.D. ADDRESS Cumberland Md DATE SIGNED Aug 8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Aug. 9, 49
NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Aug. 8, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07439

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg Rural
LENGTH OF STAY (in this place): 4 1/2 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg Md. Rural
STREET ADDRESS (If rural, give location): Frostburg Star route

3. NAME OF DECEASED (Type or Print): (First) Janet Lee (Middle) Minick (Last)

4. DATE OF DEATH: (Month) 8 (Day) 4 (Year) 1949

5. SEX: Fe

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 3/20/49

9. AGE last birthday: 4 1/2 Mos. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawernce Minick

14. MOTHER'S MAIDEN NAME: Ruth Burkey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lawernce Minick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Ruptured sac of Meningocoel — INTERVAL BETWEEN ONSET AND DEATH

751 / 757b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) of Spinal Bifida

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Mar, 1949, to 4 Aug, 1949, that I last saw the deceased alive on 4 Aug, 1949, and that death occurred at 5.50 P.m., from the causes and on the date stated above.

SIGNATURE: John B. Davis (Degree or title): M D ADDRESS: Frostburg, Md. DATE SIGNED: 8/6/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 8/6/49

NAME OF CEMETERY OR CREMATORY: Porter Cemetery

LOCATION (City, town, or county) (State): Hyndman Pa. RD #1

DATE REC'D BY LOCAL REG.: 8-6-49

REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: Harvey H. Zeigler ADDRESS: Hyndman, Pa

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BUREAU V. S.

Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07440

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (In this place) 38 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 211 Vine St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 211 Vine St.

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Montgomery (Last)

4. DATE OF DEATH: (Month) Aug. (Day) 19 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Jan. 16, 1881

9. AGE last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill-Right

10b. KIND OF BUSINESS OR INDUSTRY: Paper-Mill

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Washington Montgomery

14. MOTHER'S MAIDEN NAME: Elizabeth A. Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.: 216-07-8880

17. INFORMANT: Cora Montgomery

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Embolus	3½ Years
Antecedent cause(s) 420.1	(b) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic	3½ Years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(c) Anterior Myocardial Infarction	3½ Years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pulmonary and Generalized Edema	1 Week

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 6, 1946, to Aug 19, 1949, that I last saw the deceased alive on Aug. 19, 1949, and that death occurred at 1:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul R. Wilson M.D. Piedmont, W. Va. 20 Aug. 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: August 22, 1949 NAME OF CEMETERY OR CREMATORY: Philos Cem. LOCATION (City, town, or county) (State): Westernport Maryland

DATE REC'D BY LOCAL REG. Aug 21/49 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Ellsworth S. Boal ADDRESS: 111 Church St. Westernport, Md.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 07441

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland
STREET ADDRESS (If rural give location) Paradise St.

3. NAME OF DECEASED (Type or Print): (First) Patricia (Middle) Francis (Last) O'Brien
4. DATE OF DEATH: (Month) Aug. (Day) 8th (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): child
8. DATE OF BIRTH: July 27, 1949
9. AGE last birthday: — yrs. If under 1 year: Months —, Days 13; If under 24 hrs.: Hours —, Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William O'Brien
14. MOTHER'S MAIDEN NAME: Lillian Summers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. William O'Brien

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity - atelectasis (6 months

762.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 159 (b) gestation)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 July, 19 49, to 8 Aug., 19 49; that I last saw the deceased alive on 8 Aug., 19 49, and that death occurred at 7:32 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Allan B. Davis MD Frostburg, Md 8/8/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Aug. 8, 49
NAME OF CEMETERY OR CREMATORY: Belvedere Cemetery
LOCATION (City, town, or county) (State): Midland, Md.

DATE REC'D BY LOCAL REG. 8-8-49
REGISTRAR'S SIGNATURE: Mrs Nancy K. Roe
24. FUNERAL DIRECTOR ADDRESS: M. Eichhorn, Lonaconing, Md.

RECEIVED
AUG 13 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1454

Reg. Dist. No. 07442 4

1. PLACE OF DEATH· COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 58 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 204 Spring Street	STREET ADDRESS (If rural, give location): 204 Spring Street

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) (Last) Perkins				4. DATE OF DEATH (Month) August (Day) 25, (Year) 1949	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH: April 13 1861	9. AGE last birthday: 88 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House	10b. KIND OF BUSINESS OR INDUSTRY: House Wife	11. BIRTHPLACE (State or foreign country): Bristol, England		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: William Flook		14. MOTHER'S MAIDEN NAME: Mary Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT: Mrs. Lilly Yantz			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bronchopneumonia — 7 days

450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis — 25 yrs

107 (c) Infirmities of age

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Mouth) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-9-, 1930, to 8-25-, 1949, that I last saw the deceased alive on 8-24-, 1949, and that death occurred at 10-P m., from the causes and on the date stated above.

SIGNATURE: Wm. F. Williams (Degree or title) MD — ADDRESS: Cumberland — DATE SIGNED: 8-27-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: August 28 1949	NAME OF CEMETERY OR CREMATORY: Allegany Cemetery	LOCATION (City, town, or county) (State): Frostburg, Maryland
DATE REC'D BY LOCAL REG.: Aug. 27, 1949	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: William H. Kight	ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07443

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First) HENRY	(Middle) McCLELLAND	(Last) RAWLINGS	4. DATE OF DEATH (Month) Aug.	(Day) 29,	(Year) 19 49
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married	8. DATE OF BIRTH: 3-12-1869	9. AGE last birthday: 80 yrs.	If under 1 year: Months. / Days / If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired	10b. KIND OF BUSINESS OR INDUSTRY: farmer	11. BIRTHPLACE (State or foreign country): West Virginia	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: James Rawlings		14. MOTHER'S MAIDEN NAME: Margaret Trenter				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none	17. INFORMANT AND ADDRESS: Norval Rawlings, Mt. Savage, Md.				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	2 yrs
422.2 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Pt Inguinal Abscess	2 wks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from ....., 19 47, to Aug 29, 19 49, that I last saw the deceased alive on Aug 28, 19 49, and that death occurred at 2:00 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W M Lane MD		Frostburg Md	Aug 29 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-1-1949	Vale Summit Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-31-49	Mrs. Harvey N. Roe	J. R. Durst, Frostburg, Md.	

VS-415

RECEIVED
SEP 3 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15A

T

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

07444

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Va. COUNTY Harrison
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lost Creek
STREET ADDRESS (If rural, give location) R.D. # 1.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) Ray (Last) Richards

4. DATE OF DEATH (Month) Aug. (Day) 17, (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH March 22 1889

9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer

10b. KIND OF BUSINESS OR INDUSTRY R.R.

11. BIRTHPLACE (State or foreign country) Lost Creek N. Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Isaac Hugh Richards

14. MOTHER'S MAIDEN NAME Hattie Whitehair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 705-07-6746

17. INFORMANT Stanley Richards

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Myocardial failure	12 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Occlusion, left	
	(c) Coronary Sclerosis.	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Benedict Skitarelic (Degree or title) MD ADDRESS R2 Cumberland Md. DATE SIGNED 8/17/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Aug 19 1949

NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery

LOCATION (City, town, or county) West Milford (State) W. Va

DATE REC'D BY LOCAL REG. Aug 18, 1949

REGISTRAR'S SIGNATURE Winter R Trantz, MD

24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

RECEIVED
AUG 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07445

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A17

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eckhart Flat

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) Eckhart Flat

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) (Last) RICHARDSON

4. DATE OF DEATH: (Month) Aug. (Day) 17, (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 2/13/1874

9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wholesale Retail Merchant - Food & Grain

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Richardson

14. MOTHER'S MAIDEN NAME: Mary Eddy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Edward Richardson, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Cardiac Failure

241 Antecedent cause(s)

112 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Bronchial asthma

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Aug 17, 1949, that I last saw the deceased alive on 17 Aug, 1949, and that death occurred at 7 05 A m., from the causes and on the date stated above.

SIGNATURE John B. Davis (Degree or title) MD. ADDRESS Frostburg, Md DATE SIGNED 8/18/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 8/19/1949 | NAME OF CEMETERY OR CREMATORY: Allegany Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 8-19-49 | REGISTRAR'S SIGNATURE Mrs Harvey H. Roe | 24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

RECEIVED
AUG 24 1949
BUREAU T. S.

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07446

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 50 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location): 126 Frederick Street

3. NAME OF DECEASED (Type or Print)	(First) Bessie	(Middle) Viola	(Last) Robertson	4. DATE OF DEATH	(Month) August	(Day) 31	(Year) 1949
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH: Feby 14 1887	9. AGE last birthday: 62 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife	10b. KIND OF BUSINESS OR INDUSTRY: House	11. BIRTHPLACE (State or foreign country): Great Cacapon, West Virginia	12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME: Louis Foutch	14. MOTHER'S MAIDEN NAME: Amanda Lineburg						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY No.: None	17. INFORMANT: Leslie Robertson					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intestinal Obstruction.

570.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Post operative adhesions.

122.6

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8/31/49	19b. MAJOR FINDINGS OF OPERATION: Intestinal Obstruction.	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/30, 1949, to 8/31, 1949, that I last saw the deceased alive on 8/31/, 1949 and that death occurred at 11-05 P.m., from the causes and on the date stated above.

SIGNATURE: John K. Rogers M D (Degree or title) ADDRESS: Cumberland Md DATE SIGNED: 9/1/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Sept 3 1949	NAME OF CEMETERY OR CREMATORY: Great Cacapon Cemetery	LOCATION (City, town, or county) (State): Great Cacapon, West Va.
DATE REC'D BY LOCAL REG.: Sept. 2, 1949	REGISTRAR'S SIGNATURE: Wentz R. Wantz M D	24. FUNERAL DIRECTOR: William H. Kight.	ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

RECEIVED
SEP 5 1949
BUREAU V. S.

MEDICAL EXAMINERS CASE 07447

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 wk.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Ohio COUNTY Allen
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beaverdam
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Ross

4. DATE OF DEATH (Month) 8 (Day) 23 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 4-28-1886

9. AGE last birthday 63 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Veteran

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) World I

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS 827 E. 2nd., St. Mrs. Emma Pacey, Ottawa, Ohio

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intracranial Hemorrhage

825.5 Antecedent cause(s)

170C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Contusion of Brain

(c)

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) Near Grantsville, (COUNTY) Garrett, (STATE) Md

TIME OF INJURY (Month) 8 (Day) 17 (Year) 1949 (Hour) 12:30 p.m.

INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR? Auto accident

22. I hereby certify that I attended the deceased from Aug 24, 1949, to Aug 24, 1949, that I last saw the deceased ~~alive on~~ dead on Aug 24, 1949, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

SIGNATURE Benedict Skitarelic (Degree or title) M.D. ADDRESS R2 Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Removal

DATE 8-24-1949

NAME OF CEMETERY OR CREMATORY Beaverdam Cemetery

LOCATION (City, town, or county) Beaverdam (State) Ohio

DATE REC'D BY LOCAL REG. 8-24-49

REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe

24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

I

RECEIVED
AUG 26 1949
BUREAU T. S.

Within corporate limits

Medical Examiner's Case

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; MARYLAND; LENGTH OF STAY (in this place) 3-HRS.; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 709 MADISON AVE.,

3. NAME OF DECEASED (Type or Print): (First) MELVIN (Middle) LEROY (Last) ROUCH

4. DATE OF DEATH: (Month) AUG (Day) 13 (Year) 1949

5. SEX: male

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: OCT 21 1935

9. AGE last birthday: 13 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: OSCAR ROUCH

14. MOTHER'S MAIDEN NAME: MARY PORTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Mary Rouch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492 Immediate cause (a) Primary Atypical Pneumonia — Interval Between Onset and Death: 3 days

109 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 13., 1949., to Aug 13., 1949., that I last saw the deceased ~~alive~~ dead on Aug 13., 1949., and that death occurred at 3.30 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Benedict Skotarelic M D Acting Asst Medical Examiner Cumberland Md.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Aug 16 1949

NAME OF CEMETERY OR CREMATORY: White Oak Cemetery

LOCATION (City, town, or county) (State): (Near) Meyersdale, Pa.

DATE REC'D BY LOCAL REG.: Aug. 16, 1949

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight,

ADDRESS: Cumberland, Md.

RECEIVED
AUG 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07449

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke | LENGTH OF STAY (In this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) Oak St.

3. NAME OF DECEASED (Type or Print): (First) Isaac (Middle) Clary (Last) Rounds

4. DATE OF DEATH: (Month) August (Day) 15 (Year) 1949

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: Jan. 3, 1881 | 9. AGE last birthday: 68 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beaterman Helper | 10b. KIND OF BUSINESS OR INDUSTRY: Paper-Mill | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Nathaniel Rounds | 14. MOTHER'S MAIDEN NAME: Maratha Wilt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: 216-09-0452 | 17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Infarction - left

420.1 Pla

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Occlusion - left

(c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☑, *Inspection* ☐, *Inquiry* ☑ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Benedict Skitarelic M.D. | R² Cumberland Md. | 8/15/49.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Aug. 18, 1949 | NAME OF CEMETERY OR CREMATORY Philos Cem. | LOCATION (City, town, or county) Westernport (State) Maryland

DATE REC'D BY LOCAL REG. Aug. 18/49 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR Ellsworth S. Boal | ADDRESS 111 Church St. Westernport, Md.

RECEIVED
AUG 19 1949
BUREAU V. S.

Within corporate limits DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07450

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (In this place) 64 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL Hospital	STREET ADDRESS (If rural, give location) 128½ POLK ST.,

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	WILLIAM	ANDREW	SHARER		AUG.	25	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	Widowed	2/18/85	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ass't Train Master	RETIRED	Cumberland Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JAMES SHARER	DOLLY SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	705-10-6367	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocardial Degeneration	5 years
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arteriosclerosis	10 years
	(c) Diabetes Mellitus	" "

260 61

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 3-18-, 1943 to 8-25-, 1949, that I last saw the deceased alive on 8-25-, 1949, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm. F. Williams	M.D.	Cumberland	8-27-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 28 49	Rose Hill Cem.	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 27, 1949	Walter R. Hartz, M.D.	Louis Stein Inc	Cumberland

VS-A15

RECEIVED
AUG 30 1949
BUREAU V. S.

Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07451

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
LENGTH OF STAY (in this place): 37 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 448 Spruce St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location): 448 Spruce St.

3. NAME OF DECEASED (Type or Print): JOHN (First) WILLIAM (Middle) SKIDMORE (Last)

4. DATE OF DEATH: (Month) Aug. (Day) 25, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 1, 1897

9. AGE last birthday: 52 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Paper-Mill

11. BIRTHPLACE (State or foreign country): Mineral

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Skidmore

14. MOTHER'S MAIDEN NAME: Margaret Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-07-9384

17. INFORMANT: Dewey Skidmore

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163 Immediate cause (a) Carcinoma of lungs — Interval Between Onset and Death: One Year

Antecedent cause(s)

472 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 17, 1949, to Aug 25, 1949, that I last saw the deceased alive on Aug. 24, 1949, and that death occurred at 2:40 A. m., from the causes and on the date stated above.

SIGNATURE: Paul B Wilson (Degree or title): M.D. ADDRESS: Piedmont, W.Va. DATE SIGNED: Aug 26 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE: Aug. 27, 1949 NAME OF CEMETERY OR CREMATORY: Philos Cem. LOCATION (City, town, or county) (State): Westernport Maryland

DATE REC'D BY LOCAL REG.: Aug 27 49

REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: Ellsworth S. Boal ADDRESS: 111 Church St. Westernport, Maryland

RECEIVED
AUG 29 1949
BUREAU V. S.

R. Reeves

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07452

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; LENGTH OF STAY (in this place) 74 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St. Extended

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) Main St. Extended

3. NAME OF DECEASED (Type or Print): (First) CLARA (Middle) BELLE (Last) SMITH

4. DATE OF DEATH: (Month) Aug. (Day) 24, (Year) 19 49

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Aug. 12, 1875

9. AGE last birthday: 74 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Stipa

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis — Interval between onset and death: 3 days -

332 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension Cerebral

(c) Arteriosclerosis -

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Chronic Myocarditis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/20, 1949, to 8/24, 1949, that I last saw the deceased alive on 8/24, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

C W Reeves M.D. Westernport Md 8/24/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Aug. 27, 1949 — NAME OF CEMETERY OR CREMATORY: Philos Cem. — LOCATION (City, town, or county) (State): Westernport Maryland

DATE REC'D BY LOCAL REG.: Aug. 27/49 — REGISTRAR'S SIGNATURE: Hazel Baker M.D.

24. FUNERAL DIRECTOR: Ellsworth S. Boal — ADDRESS: 111 Church St. Westernport, Maryland

RECEIVED
AUG 29 1942
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07453

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (in this place) 35 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 Allegany St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) 2 Allegany

3. NAME OF DECEASED (Type or Print): (First) Peter (Middle) Francis (Last) Stakem

4. DATE OF DEATH: (Month) Aug. (Day) 21 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3-3-1880
9. AGE last birthday: 69 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prop. of Pool Room
10b. KIND OF BUSINESS OR INDUSTRY: Bowling
11. BIRTHPLACE (State or foreign country): Ocean, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Stakem
14. MOTHER'S MAIDEN NAME: Ellen Cullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. George Richards

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	Sudden death
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Angina Pectoris	6 months
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 19....., to August 21, 1949, that I last saw the deceased alive on Aug. 21, 1949, and that death occurred at 3.30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) E. Don Eyler M.D. ADDRESS Lonaconing Md. DATE SIGNED Aug 22-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-24-'49	St. Peter & Paul Cemetery	Cumberland Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
8-24-49	Jeanette M Boal	J. M. Eichhorn, Lonaconing, Md.

RECEIVED
AUG 29 1949
BUREAU Y. S.

Within corporate limits

07454

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH · COUNTY: Allegany · MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place): 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 8 Race Street

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland · COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 8 Race street

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) A (Last) Starrett

4. DATE OF DEATH: (Month) Aug. (Day) 14 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widow

8. DATE OF BIRTH: Jan 5, 1869

9. AGE last birthday: 80 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Headsville, W Va

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Mike Staab

14. MOTHER'S MAIDEN NAME: Binnie Hickmen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NP | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Otto C. Bean (son-in-law)

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure	10 years
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Arteriosclerotic cardio-	
	(c) vascular disease	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Benedict Skitarelic Acting Deputy Medical Examiner M.D. R - Cumberland Md 8/14/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Aug. 16, 1949 | NAME OF CEMETERY OR CREMATORY: St. Lukes Lutheran Cem | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug. 15, 1949 | REGISTRAR'S SIGNATURE: Walter R. Frantz M.D. | 24. FUNERAL DIRECTOR: John J. Hafer | ADDRESS: Cumberland, Md.

RECEIVED
AUG 23 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07455

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): 38 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 69 Armstrong St

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Trahamtown
STREET ADDRESS (If rural, give location): 69 Armstrong St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Florence Helen Sterry

4. DATE OF DEATH (Month) (Day) (Year): 8 6 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 5-26-1876
9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: George Vincent
14. MOTHER'S MAIDEN NAME: Suzanna Ketterhame

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Gladys Sterry

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

442 Immediate cause (a) Cardio-vascular renal disease — 1 year.

131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility

(c) arterio-sclerosis.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. as above.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1, 1949, to 8-6, 1949, that I last saw the deceased alive on 8-6, 1949, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H.C. Diehl M.D. — ADDRESS: Frostburg Md. — DATE SIGNED: 8/8/49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 8-9-1949 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 8-9-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy H Roe — 24. FUNERAL DIRECTOR: Jacob Hafer — ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07456

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 70yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 78 Mt. Pleasant St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 78 Mt. Pleasant St.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) I. (Last) Tagan

4. DATE OF DEATH (Month) 8 (Day) 6 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Jan. 30-1860
9. AGE last birthday 89 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machanic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME John F. Tagan
14. MOTHER'S MAIDEN NAME Katherine Rosenberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT John Tagan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cornerona of Jaw (Mandible) — INTERVAL BETWEEN ONSET AND DEATH 1 year and 6 months

196 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

45d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 1949, to August 6, 1949, that I last saw the deceased alive on July 20, 1949, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE J. H. Johnson (Degree or title) M. D. ADDRESS Cumberland Md DATE SIGNED 8-8-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8-9-1949
NAME OF CEMETERY OR CREMATORY St. Michaels Cem.
LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REG. 8-11-49
REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 18 1949
BUREAU V. S.

07457

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 57 First St

3. NAME OF DECEASED (Type or Print) (First) Alfred (Middle) Wm. (Last) Taylor
4. DATE OF DEATH (Month) 8 (Day) 9 (Year) 1949
5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Aug. 14-1910
9. AGE last birthday 38 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiters
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Jerome Taylor
14. MOTHER'S MAIDEN NAME Mary Elizabeth Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.2
16. SOCIAL SECURITY NO. 220-03-7752
17. INFORMANT Leroy Taylor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Toxic Peritonitis	10 days
322.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Alcoholism	years
129	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION NONE
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) ✓
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓ (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1949, to August 9, 1949, that I last saw the deceased alive on Aug. 9, 1949, and that death occurred at 12:35 P.m., from the causes and on the date stated above.

SIGNATURE Marthula Pothakin M.D. (Degree or title) ADDRESS 48 Broadway - Frostburg, Md. DATE SIGNED 8/11/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 8-12-49
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg, Md. (State)
DATE REC'D BY LOCAL REG. 8-12-49
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 12 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07458

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 212 Harrison St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 212 Harrison St.

3. NAME OF DECEASED (Type or Print): (First) DORA (Middle) E. (Last) WADE

4. DATE OF DEATH: (Month) August (Day) 9, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July 19, 1873

9. AGE last birthday: 76 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hiram Rice

14. MOTHER'S MAIDEN NAME: Caroline Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Robert C. Wade

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	congestive heart failure	6 week
420.0 Antecedent cause(s) 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	arteriosclerotic heart disease	2 years
	(c)	—	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-1-, 1949, to 8-9-, 1949, that I last saw the deceased alive on 8-9-, 1949, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE: L. Wm. Wings (Degree or title) MD

ADDRESS: 59 Greene St.

DATE SIGNED: 8-10-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Aug. 12, 1949

NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Aug. 12, 1949

REGISTRAR'S SIGNATURE: Walter K. Hartz, M.D.

24. FUNERAL DIRECTOR: William H. Kight

ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
AUG 16 1949
BUREAU V. S.

Within corporate limits

07459

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.; LENGTH OF STAY (In this place) 1 DAY; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; STREET ADDRESS (If rural, give location) 313 MARYLAND AVE.,

3. NAME OF DECEASED (Type or Print): (First) John (Middle) C. (Last) Wells

4. DATE OF DEATH: (Month) AUG. (Day) 16 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 11-28 1881

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: B & O R R.

11. BIRTHPLACE (State or foreign country): Roneke, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 705-09-8673

17. INFORMANT: MEMORIAL HOSPITAL,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac Failure	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Lobar Pneumonia - Right.	3 days.
	(c)	

490
108

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☑, *Inspection* ☐, *Inquiry* ☑ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Benedict Skitarelic	M. D.	R² Cumberland, Md.	8/16/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 19 1949	Rose Hill Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 19, 1949	Walter L. Mantz, M.D.	William H. Kight,	Cumberland, Md.

RECEIVED
AUG 23 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07460

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.	STREET ADDRESS (If rural, give location) 222 Paca St.,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
HARRY	RANDOLPH	WILLISON	Aug. 23, 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Dec. 24, 1877	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stationary Engineer	Potomac Edison	Cumberland, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Willison	Virginia Kelso

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		Mrs. Anna Willison

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) myocardial degeneration	Chronic
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —	
(c) —	

443
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED ~~While at~~ Work ☐ ~~Not While~~ At work ☐	HOW DID INJURY OCCUR?
— m.		

22. I hereby certify that I attended the deceased from —, 19 45, to 8/23, 19 49, that I last saw the deceased alive on 8/23, 19 49, and that death occurred at 4 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John K Rozzell M D		Cumberland Md	8/25/49

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8/26/49	S. S. Peter & Paul	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 26, 1949	Walter K. Wantz M.D.	Charles L. George	Cumberland, Md.

VS. A15

Bozeman

RECEIVED
AUG 30 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

07461

Reg. Dist. No. 4

M — The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ~~Route 2~~, Cumberland, Rural
LENGTH OF STAY (in this place): 50 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 2, Baltimore Pike

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ~~Route 2~~, Cumberland Rural
STREET ADDRESS (If rural, give location): Route 2, ~~Cumberland~~, Baltimore Pike

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
DENNIS	A.	Wilson	8	25	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Widowed	May 17 1871	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Carpenter	Building Houses	Murley's Branch, Md	US

13. FATHER'S NAME: John Wilson

14. MOTHER'S MAIDEN NAME: Atza (Wilson) [redacted]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Mrs. Marvin Hinkle

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 932	(b) Hypertensive arteriosclerotic	10 yrs.
	(c) cardiovascular disease	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Benedict Stutarelis	M.D.	R-2 Cumberland, Md	8/26/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	August 29 1949	Mt Plesant Cemetery	Route 2, Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 27, 1949	Winter R. Wantz, M.D.	William H. Kight,	Cumberland, Md.

VS. A15A

RECEIVED
AUG 30 1949
BUREAU V. S.